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ABSTRACT

While academia has largely ignored the problem of adolescent depression until fairly recently, secondary educators have been confronting its symptoms, correlates, and outcomes for years. Research shows that lay adults such as parents and teachers often fail to notice depression in young people who report extensive symptoms in a clinical interview. Goals of the research reported here include exploration of an expanded referral net that includes, in addition to referral by school personnel, self-referral, referral by peers, and screening using standardized instruments. Two models, based on direct research, are presented. The first model states that depression is more likely when perceived psychological demands on an individual exceed perceived resources available for meeting those demands. The second model suggests a useful framework for conceptualizing referral issues. Both quantitative and qualitative methods were used in interviews of approximately 350 students and 30 teachers in a rural middle school and high school in southeastern Michigan. Student depression was measured by self-report, interviewer observation, and teacher observation. While the quantitative data collected allowed for the establishment of normative standards and reliability tests for the instrument being developed, the qualitative data allowed each to serve as a check for the other, ensuring the validity of the findings and suggesting areas for further research. (LLL)

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Multiple Assessments of Affective Context and Referral Practices in Secondary Classrooms

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Multiple Assessments of Affective Context and Referral Practices in Secondary Classrooms

Adolescent depression poses a significant threat to the goals of secondary education, a threat surmountable only when the preliminary challenge of identifying and referring depressed adolescents is met. Psychology offers education the theoretical panorama, diagnostic framework, and assessment expertise to potentially meet the challenge; however, this potential can be realized only as psychology enters the classroom and the home to understand and eventually influence the cognition, behavior, affect, and environment of the depressed student. The research presented here attempts such an entry. Goals of this research include development of a screening and diagnostic instrument geared specifically toward adolescents; investigation of the symptoms, causes, and correlates of depression in adolescent students; and assessment of awareness on the part of students and school personnel of depressive symptoms, intervention options, and referral channels within schools.

Depressed students affect educational processes and are affected by them in a variety of ways. In addition to the threat of suicide, depressed adolescents may exhibit social withdrawal, decreased effectiveness or productivity at school, irritability or anger toward teachers and peers, inability to respond to rewards or praise, pessimism, restlessness, grouchiness, aggression, and lethargy. Running away from home, drug and alcohol abuse, and scholastic underachievement are believed to be common associated features (American Psychiatric Association, 1987). Clearly young people who are lethargic, have difficulty concentrating, feel hopeless and helpless, withdraw or act out socially, etc. are simply less likely to learn, and more likely to interfere with the learning

of others.

Thus, while academia has largely ignored the problem of adolescent depression until fairly recently, secondary educators have been confronting the symptoms, correlates, and outcomes of adolescent depression, however labelled, for years (Schloss, 1982; Forrest, 1983). Nevertheless, past approaches to depression that have emphasized psychoanalytic or medical treatments have been outside of the legitimate realm of school intervention. Current successes with cognitive, behavioral, and interpersonal approaches to depression (Beck, Rush, Shaw & Emery, 1979; Lewinsohn, Sullivan & Grosscup, 1980; Klerman, Weissman, Rounsaville & Chevron, 1984), particularly among adolescents (Bedrosian, 1981; Clarke & Lewinsohn, 1986; 1988), introduce new strategies schools can realistically deploy in combatting adolescent depression. These approaches work within cognitive processes such as reasoning, logical analysis, problem solving, and abstract thought. These interventions target cognitive distortions, poor social skills, and ineffective coping styles.

Even if schools do not choose to intervene directly in remediating or preventing depression in students, they have an obligation to inform students of major health problems affecting them--of which depression is the most common in the area of mental health--and referring them to appropriate resources for help. However, research shows that lay adults such as parents and teachers often fail to notice depression in young people who report extensive symptoms in a clinical interview (Rutter, Graham, Chadwick & Yule, 1976). This failure represents a major break in the referral chain that should lead to intervention on a student's behalf.

Goals of the research reported here include exploration of an expanded referral net

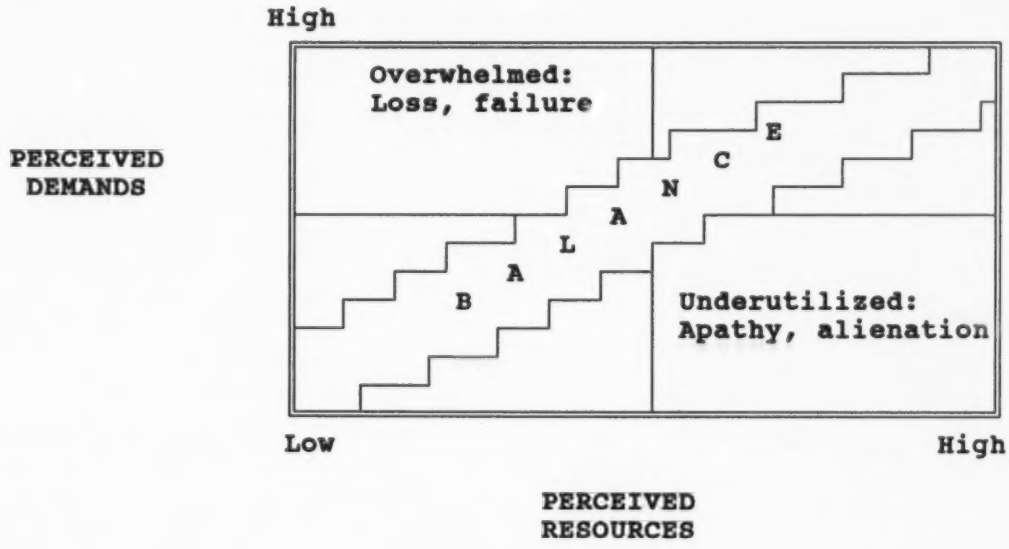
that includes--in addition to referral by school personnel--self-referral, referral by peers, and screening using standardized instruments based on recognized risk factors and symptoms. These potential referral sources were developed and investigated during the course of this research project using a variety of research formats, informants, referents, settings, and time frames.

Having described briefly the phenomena this research explores, I will now present two models for student and teacher cognitions relevant to adolescent depression and the referral of depressed students for further help. I will then describe the methodology used, and present a rationale for combining quantitative and qualitative methods.

Two models guided this research into the cognitive bases of adolescent depression, and its referral in secondary education settings. The first model (see Figure 1) states simply that depression is more likely when perceived psychological demands on an individual exceed perceived resources available for meeting those demands. Regardless of the overt, objective nature of these demands and resources, it is the individual's affective and cognitive perception of demands and resources and the balance between them that influences depression. Despite realistic aspects of many demands, the individual also actively appraises and even creates or constructs the demand he experiences (Mahoney, 1988).

Appraised aspects of the demand state include the meaning given to events, the extent to which they are allowed into awareness, or the perception of control over them. This model suggests that actual stresses and abilities would imperfectly predict depression because of the moderating influence of personal perceptions and cognitive

Figure 1: Perceived Demand-Perceived Resource Balance

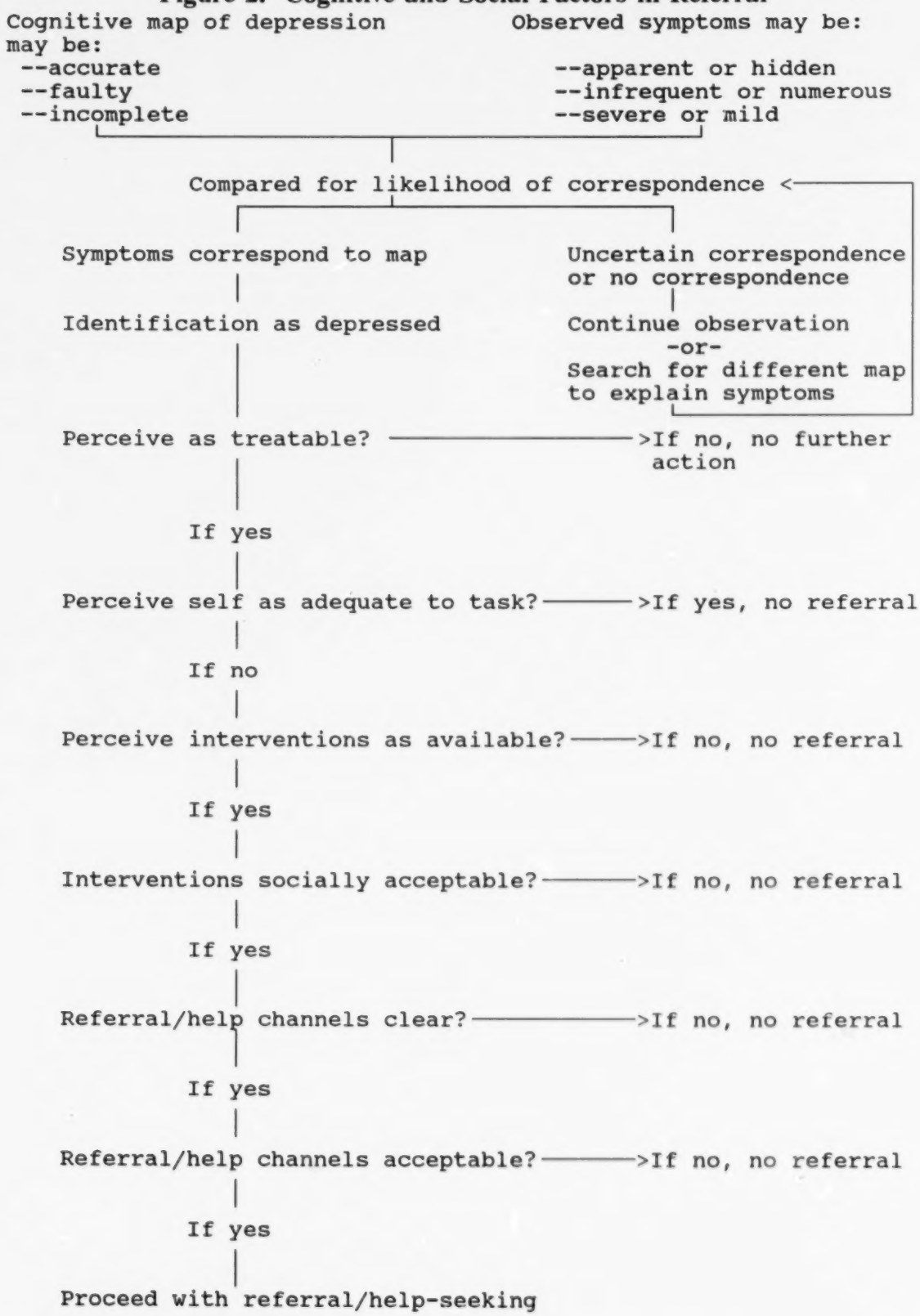


structures (Billings & Moos, 1985; Heppner, Kampa & Brunning, 1987; Nezu, Nezu, Saraydarian, Kalmar & Ronan, 1986; Wise & Barnes, 1986; Olinger, Kuiper & Shaw, 1987). Nevertheless, certain loss situations are more likely to deplete the personal assessment of resource unless facilitating, caring, supporting behavior of others is forthcoming to provide a balancing perception of increased resource. Support systems providing coping models, facilitation of affective expression, and reinforcement of coping responses attenuate depressive response to loss. Where members of an individual's support system criticize, withdraw, demand or withhold, perceived demands increase, or perceived resources diminish further.

The second model (see Figure 2) suggests a useful framework for conceptualizing referral issues. Whether the depressed individual seeks help directly, or is referred by others, behavior such as seeking help or requesting an evaluation can be predicted by the extent to which the symptoms I perceive correspond to my cognitive map of depression. The referral process can break down if the internal map is inaccurate, faulty, or incomplete, or if the observed symptoms are hidden, infrequent, or mild. Once a correspondence is found between the observed symptoms and the internal map, the referral process can still break down if the individual does not perceive depression as treatable, perceives him- or herself as capable of handling the problem alone, is unaware of intervention options, finds intervention socially unacceptable, or perceives referral channels as unclear or undesirable.

Research reported here derives from these two models of adolescent depression and referral. This research was conducted among approximately 350 students and 30

Figure 2: Cognitive and Social Factors in Referral



teachers in a rural middle school and high school in southeastern Michigan. Almost half of the students in the schools participated in the research, including students from an alternative program for high school drop-outs. Three research questions guided the study: (1) What behaviors, cognitions, and affects are associated with adolescent depression? (2) What behaviors, cognitions, and affects affect the referral practices of students and teachers? (3) How do depressed and non-depressed adolescents cope with stress, or assist peers in coping with stress?

A combination of quantitative and qualitative methods were used to provide a multi-faceted view of the target population (see Figure 3). Column 5 shows the research formats used. Students were asked to complete three self-report questionnaires with ranking and rating items, Likert scales, and open-ended questions. Some of these questions were based on a commonly used symptoms questionnaire for assessing adult depression. These questions became the basis for the Adolescent Depression Inventory, an instrument developed and tested as part of this research. As shown in Column 1, these questionnaires were completed at four different time intervals over a six month period, allowing a longitudinal analysis of some data.

About 50 students were also interviewed by one of three professional psychologists using a semi-structured interview format to assess their depression. Using more than one method and format for assessing depression is necessary in research that compares depressed and non-depressed subjects because it ensures that depressed subjects have been identified by qualitative as well as quantitative methods. This approach has been

Figure 3: Data Collection

Time	Goals	Informants	Locale	Data Format
Time 1	First screening for depression and risk factors	327 students re: self	in class paper	rated # data
	Assess teacher awareness of depression & referral	30 teachers re: self & students	inservice meeting paper	rated # data open questions mini-cases
Time 2	Second screening	278 students re: self & peers	in class paper	rated # data open questions
	Assess student awareness of depression & referral			
	Assess teacher diagnostic skill	31 teachers re: students	in class	rated # data open questions observation
Time 3	Validate Adol. Depression Scale	50 students re: student & family	one-on-one interview	rated # data open questions semi-struct'rd questions interviewer's observations
	Explore risk factors			
	Explore coping skill			
Time 4	Reliability tests	72 students re: self & family	at home	rated # data open questions
	Longitudinal analys. of risk factors			
	Explore family issues			

recommended as a means of providing "multiple gates" for selecting depressed subjects, ensuring that clinical depression is not assumed on the basis of a paper-and-pencil, self-report questionnaire alone (Kendall, Hollon, Beck, Hammen, & Ingram, 1987; Kendall, Cantwell, & Kazdin, 1989).

The structured interview included questions about specific symptoms, follow-up questions, and exploratory questions based on hypothetical and real situations from the students' life. Interviewer observations of the students were also recorded and considered in making assessments of student depression. Following the semi-structured, clinical interview, students heard four situations described and reported how they would feel, what they would think, and what they would do in each situation. The situations dealt with receiving criticism, being overloaded with homework and chores, being in a social setting in which one has no close friends, and failing an important test. Students also described the most difficult problem they had faced and how they coped with it. They were also asked what kept them from being depressed, or more depressed. Students interviewed included students who had received very high or very low scores on the depression scale, as well as very high or very low scores on questions measuring hypothesized risk factors for depression.

In addition to multiple formats and time frames, multiple informants provided information. Student depression was measured by self-report, interviewer observation, and teacher observation, providing three perspectives on student symptoms. The goal of having multiple informants, as with the goal of having multiple data-gathering formats and multiple time frames, is to assure the validity of the data gathered by measuring it

from a variety of perspectives. Students were asked to report their observations of their own depression, coping skills, and referral behavior and cognitions. They also reported on their observations of the depression and coping skills of their peers, and those of their parents, providing a variety of perspectives on the cognitions and determinants relative to depression and referral in these students. Students completed various aspects of the research in classrooms as groups, in one-on-one meetings in a private setting, or alone at home.

A combination of qualitative and quantitative approaches was appropriate to the questions being addressed in this research for two major reasons. First, the research sought to establish a paper-and-pencil questionnaire for measuring adolescent depression. The use of more qualitative methods was essential to assure the construct validity of the instrument. Second, the research was exploratory, depending on responses to open-ended questions to explore the risk factors, family dynamics, and spontaneous cognitions associated with student depression. While the quantitative data collected allowed us to establish normative standards and reliability tests for the instrument being developed, the qualitative data allowed exploration of aspects of depression and its referral unique to adolescents and school settings. The combination of quantitative and qualitative data allowed each to serve as a check for the other, ensuring the validity of the findings and suggesting areas for further research.

Qualitative data adds a richness and depth to the research process that cannot be fully appreciated without sharing it. I would like, therefore, to conclude with a simple example of the kind of fertile, encompassing data that open-ended, qualitative methods

can produce. Even though every one of the symptoms suggested in this example are familiar to clinicians and educators alike, the poignancy and intensity exhibited here cannot be adequately communicated in Likert scales and empirical analysis. This information has a quality to it, without which we may miss the enormous human relevance of the phenomenon we are studying. The response was written at the end of a questionnaire in response to that most ubiquitous of qualitative questions: "Do you have any other comments?" An eighteen-year-old female who had lost six friends to suicide and car accidents in the last two years responded:

October 2, 1988 I was in U of M's depression hospital until November 7. I took 50 prescription pills, but was not found out for a week. The first time I started taking pills was when I failed 8th grade. I tried that time because I was supose (sic) to graduate with these people. Nobody in my school accepts me, and I just had two long term relationships end. I am not depressed now, but when something else goes wrong I will again become too depressed to live. . . . Twice I have been rushed to the U of M psyciatric (sic) ward. I also keep a fifth of Jack Daniel's and a fifth of Tequila in my schoolbag with my own shot glass [for] when times get hard. I also use sex to make me feel better. I need help, and have tried 2 psyciatrists [sic], which have not helped. I don't like who I am, but I am trying thank you! I will help you on your research as much as you need. I have seen enough suicides among teens, and don't want to see others, including my own.

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